NAVMED 6550/14 (5-80) S/N 0105-LF-206-5570

PATIENT DATA BASE

SECTION I **Please complete this form concerning your health. The information you provide will be used as a basis for planning your care.**

1. What problem(s) brought you to the hospital? _____

2. What do you know about your problem(s)? _____

3. What are you most concered about right now? _____

4. What significant health problems have you had? _____

5. Have you ever been hospitalized before? ☐ No ☐ Yes Date _____

6. For what problems have you been hospitalized? _____

7. List drugs/medical you are taking:

Drug	Date/Time Last Taken	Drug	Date/Time Last Taken

8. Do you have allergies to any of the following? If so, please list.
   - medicines: No ☐ Yes ☐ _____
   - foods: No ☐ Yes ☐ _____
   - adhesive tape: No ☐ Yes ☐ _____
   - other No ☐ Yes ☐ _____

9. List the kinds of allergic reactions you have to the items above. _____

10. Do you have any special dietary requirements/restrictions?
    No ☐ Yes ☐ (please explain) _____

ADDRESSOGRAPH

11. What are your usual patterns of living concerning; describe

sleeping _____

smoking _____

alcohol intake _____

bowel elimination _____

urine elimination _____

12. Please check the activities with which you need assistance:

☐ bathing ☐ eating ☐ walking ☐ dressing

Explain: _____

_____

_____

13. I require the following items **I have these items with me**

☐	contact lenses	☐
☐	hearing aid	☐
☐	dentures	☐
☐	prosthetic device	☐
☐	ostomy equipment	☐
☐	wheel chair	☐
☐	walker/cane	☐
☐	glasses	☐

Explain: _____

_____

_____

14. What is your occupation? _____
15. Are you currently employed? _____
16. What is the highest level of education you have completed? _____

Please place a check mark in the box next to each symptom or problem you are having. If you are having no problems, check no difficulty.

Breathing:

☐ NO DIFFICULTY

☐ coughing
☐ wheezing
☐ shortness of breath
☐ difficulty breathing when lying down
☐ pain
☐ other

Explain: _____

_____

_____

Circulation and heart

☐ NO DIFFICULTY

☐ palpitations
☐ dizziness
☐ bruising
☐ chest pain
☐ swelling
☐ headache
☐ fainting
☐ other

Explain: _____

_____

_____

Stomach/bowels:

☐ NO DIFFICULTY

☐ nausea/vomiting
☐ difficulty swallowing
☐ indigestion
☐ bleeding

☐ constipation
☐ diarrhea
☐ pain
☐ change in habits
☐ other

Explain: _____

Bladder/kidney:

☐ NO DIFFICULTY

☐ trouble holding
☐ burning
☐ bloody urine
☐ frequency

☐ color change
☐ difficulty starting stream
☐ pain/pressure
☐ other

Explain: _____

Muscles/bones:

☐ NO DIFFICULTY

☐ cramping
☐ aches/pains
☐ swelling

☐ trouble moving
☐ weakness
☐ other

Explain: _____

Reproductive:

☐ NO DIFFICULTY

☐ bleeding
☐ discharges

☐ change of life problem
☐ pain
☐ other

Explain: _____

Skin:

☐ NO DIFFICULTY

☐ sores
☐ dryness/cracking
☐ excessive moisture
☐ rash

☐ temperature/color change
☐ lumps
☐ changes in moles
☐ other

Explain: _____

ADDRESSOGRAPH

Nerves:

☐ NO DIFFICULTY

☐ numbness
☐ tingling
☐ tremors
☐ seizures/convulsions

☐ paralysis
☐ poor coordination
☐ forgetfullness
☐ other

Explain: _____

Vision/Hearing/Speech:

☐ NO DIFFICULTY

☐ blurred/double vision
☐ light sensitivity
☐ difficulty seeing
☐ ringing in ears

☐ difficulty hearing
☐ difficulty speaking
☐ voice changes
☐ pain/pressure
☐ other

Explain: _____

Nerves:

☐ NO DIFFICULTY

☐ anxiety/nervousness
☐ tension
☐ restless

☐ depression
☐ irritability
☐ other

Explain: _____

Is there any additional information you would like to give us? _____

Are you currently being assisted by any community services? _____

If you need assistance after you are discharged from the hospital, will there be someone to provide it? _____

_____ Signature of Patient

_____ Signature of person completing form (if other than patient)

SECTION II **(To be completed and signed by a registered nurse)**

NURSING SUMMARY: _____

PATIENT PROBLEMS IDENTIFIED AND LISTED ON CARE PLAN ☐ YES: ☐ NO:

_____ Signature and date